

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC		Response Timely Filed? (X) Yes () No	
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504		MDR Tracking No.: M4-04-1024-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's TPCIGA for Petrosurance Casualty Rep. Box # 50		Date of Injury:	
		Employer's Name: Nicklos Drilling Co.	
		Insurance Carrier's No.: 20029242	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-28-02	11-1-02	Inpatient Hospitalization	\$52,833.07	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

M – Code used improperly to designate reimbursement pursuant Acute In-Patient Stop Loss per Fee Guideline. F – Payment not in accordance with Acute In-Patient Stop Loss Fee Guideline.

PART IV: RESPONDENT'S POSITION SUMMARY

A line by line audit of the remaining charges of \$72,715.75 was then conducted and Vista's grossly inflated charges were reduced to the usual and customary amount. These reductions totaled \$30,872.39... Subtracting these usual and customary reductions... The total audited charges of \$77,663.36... This resulted in reimbursement of \$58,247.52.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 4 days based upon bilateral laminectomy L2-S2 with foraminotmies L2-S1 bilaterally, excision of lumbar disc L3-4, removal of hardware L4 – S1, Anterior fusion from pposterior approach using BAK cages, Lateral transverse fusion L3-S1, lateral transverse fusion, L3-S1, posterior lateral facet fusion L3-S2.

The requestor billed \$168,060.75 for the hospitalization. In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$90,220.00 for the implantables. The actual cost for the implants per invoices was \$23,730.00

The requestor also billed \$5125.00 for a back brace, and actual cost was \$1025.00.

\$168,060.75 minus \$90,220.00 = \$77,840.75. This number minus charges for LSO back brace = \$72715.75. This number minus personal convenience = \$82.55 = \$72,633.20. Minus the insurance carrier's usual and customary charges reduction of \$30,872.39 = \$41,760.81.

Medcheck's line by line audit audit charges = \$41,760.81 plus the \$26103.00 (implantables cost + 10%) plus \$1127.50 (LSO back

brace) = \$68,991.31.

The total audited charges associated with this admission equals \$68,991.31.. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$51,743.48

The insurance carrier paid the requestor \$58,247.52 for the inpatient hospitalization.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Authorized Signature

Elizabeth Pickle

Typed Name

April 27, 2005

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____